Reason and Compassion on Gender Medicine

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Florida adopts the more cautious European model of pediatric care—and exposes American "gender-affirming" advocates as incompetent and dishonest.

Leor Sapir November 4, 2022 Health CareThe Social Order

Florida has decided to regulate medical care for gender-dysphoric minors. The state's Boards of Medicine and Osteopathic Medicine ruled that the standard treatment for gender-dysphoric youth under 18 will no longer be puberty blockers and cross-sex hormones, but psychotherapy.

Contrary to the media frenzy that erupted, Florida is not planning to prevent minors already on the medical track from receiving hormones—what critics call "forcible detransition." Instead, the new rule includes a grandfather clause, permitting these individuals to continue their medical transition. As for prospective cases, the Board of Medicine voted not to allow further pediatric procedures, while the Board of Osteopathic Medicine voted to allow them in exceptional cases under an Institutional Review Board-approved research protocol. If proponents of "gender-affirming" interventions want to assert that puberty suppression and cross-sex hormones are "medically necessary," the onus should be on them to prove it using the standard techniques of scientific corroboration.

In short, Florida seems poised to adopt the Scandinavian—and, it appears, the British—model of caring for gender-dysphoric minors. Rather than imposing legislative actions that put politicians between the doctor and the patient, Florida decided to invoke the existing mechanism for the regulation of health practices, putting the decision in front of state medical boards. The Florida Medical Board's five-hour televised discussion made it obvious that its practicing physicians are first and foremost professionals who understand the uncertainties of clinical care. Florida medical authorities' nuanced decision is evidence of how reason and compassion can work in tandem.

Given the precedential importance of a Ron DeSantis administration's decision largely to phase out "gender-affirming care," it was not surprising that proponents of the controversial protocol would enlist their most capable experts to testify against it. But the three experts did little more than expose the naked emperor.

The first to testify was Kristin Dayton, a pediatrician and member of the Florida chapter of the American Academy of Pediatrics. Dayton assured the board that her approach to treating youth in distress is based on the guidelines of the World Professional Association for Transgender Health (WPATH) and the Endocrine Society—the former having committed itself to ideology over science explicitly and recently done away with age minimums for hormones and surgeries, the latter having rated its own recommendations in favor of hormonal interventions as resting on "low" or "very low quality" evidence. An independent, peer-reviewed analysis in 2021 gave WPATH's guidelines a quality score of zero out of six and ES's guidelines a score of one out of six. Dayton also cited the American Academy of Pediatrics and other American medical organizations, apparently unaware of the extremely weak evidentiary basis of these groups' recommendations.

Finally, Dayton claimed that "a study" (she did not specify which) showed that gender-dysphoric youth who received puberty blockers did better than those who did not get blockers when compared with "cisgender" peers. To date, some studies have shown no improvement in mental health in patients receiving hormones, and some have shown improvement but without the ability to infer that the improvement was caused by the hormones as opposed to psychotherapy, which participants are also given. In other words, the number of studies that demonstrate the superiority of hormones to psychotherapy is zero. This is why systematic reviews of the evidence by health authorities in Sweden, Finland, and the U.K. found that hormonal interventions lack adequate justification.

Next to testify against Florida's proposed rule was Aron Janssen, a pediatric psychiatrist at the Pritzker Department of Psychiatry and Behavioral Health at Chicago's Lurie Hospital. The billionaire Pritzker family, which includes among its ranks the governor of Illinois and his transgender cousin, has been providing the financial resources for advancing much of the transgender movement's policy goals. Janssen's testimony was remarkable and should be seen by states that seek to emulate Florida's approach as a compelling reason to get "affirming" experts to speak on the record. After his opening remarks, David Diamond of Florida's medical board asked Janssen why Europe has recently moved in a more "conservative" direction on pediatric gender medicine. Janssen's response was typical of the pro-"affirming" camp: he seemed to deny that Europe *is* in fact more conservative. In his words: "The best data that we have, and the best longitudinal data that we have about transgender youth, comes primarily out of the Dutch clinic . . . That's the prevailing model that most American clinics have based their care upon." Let's set aside, for the moment, the serious and well-documented internal weaknesses of the Dutch study. (The U.K.'s systematic review rated the certainty of evidence in the Dutch studies as "very low.")

If this is "the best data that we have," pediatric gender medicine is indeed in a state of crisis.

No less important, the Dutch researchers themselves seem to disagree with Janssen as to whether American clinics are basing their care models on the Dutch research. In 2021, Thomas Steensma remarked that "the rest of the world is blindly adopting our research," a reference to the fact that the major clinical cohort presenting at pediatric gender clinics today—females with adolescent-onset gender dysphoria/distress and elevated mental-health co-morbidities—would not have qualified for the Dutch study. Annelou de Vries, the lead author of the Dutch study, recently expressed similar reservations in the pages of the American Academy of Pediatrics' journal, *Pediatrics*. An investigative report by Reuters recently found that American clinicians working with gender-dysphoric youth themselves believe that the Dutch model is not being followed. "[D]octors and other staff at 18 gender clinics across the [United States]," the report found, "described their processes for evaluating patients. None described anything like the months-long assessments de Vries and her colleagues adopted in their research."

Early this year, a controversial study by Diana Tordoff on minors at Seattle Children's Hospital revealed that 66 percent of teenagers referred to its gender clinic were put on hormones. In her response to a critic, Tordoff said that even minors with serious co-occurring mental health problems remain eligible for hormones—another strong indication that major pediatric gender clinics in the country are not doing what Janssen believes they are doing. Either Janssen misunderstands the Dutch study and protocol, or he is woefully out of touch with clinical realities on the ground, or he is not telling the truth. Whichever it is, his testimony should be a wake-up call for the medical community, serious journalists, and government regulators to start asking questions.

The third and final witness, and probably the key one testifying on behalf of "gender-affirming care," was Meredithe McNamara, a physician and assistant professor of pediatrics at the Yale School of Medicine who provides clinical care for "transgender and gender expansive" patients under the age of 25.

McNamara's testimony was remarkable for a number of reasons. For one, she was unable to articulate how she can distinguish between a minor going through a temporary phase within a broader process of identity consolidation and a minor whose "gender identity" is already fixed for life. While we do not know how many of the current "trans youth" will continue to identify as trans in mature adulthood, we do know that the majority of prepubescent children—from 61 percent to 98 percent—will *not* persist in their trans identity if allowed to come to terms with their bodies through puberty. And we now understand the risks of socially "affirming" them:

according to a recently published study, 97.5 percent *will* persist (or fail to come to terms with their bodies) if "affirmed" through social transition. As Michael Biggs, who testified in favor of the proposed rule, has pointed out, 96 percent to 98 percent of those who start on puberty blockers will continue on to cross-sex hormones. In other words, once a child is socially transitioned, the medical pathway becomes the rule, not the exception.

Recognizing this potential for iatrogenesis (a medical intervention that is itself the cause of illness), the U.K.'s National Health Service now discourages social transition for children and recommends it for adolescents only on the basis of a gender-dysphoria diagnosis and only with informed consent—a requirement generally reserved for risky medical interventions. Neither McNamara nor any of the other pro-"affirming" experts showed any concern whatsoever about a problem now troubling their professional counterparts in Europe. This is another sign of the unchecked arrogance sweeping through the U.S. medical profession—a form of American exceptionalism we can do without.

When asked how she makes treatment recommendations, McNamara's answer was consistently evasive. "People are ready for different things at different stages in their life and their journey," she said. "It's a really tough question to answer. It's a tough question to answer with an absolute . . . it's impossible actually."

Does this mean that McNamara is just winging it? Trusting her gut? Medicine, it is said, is both art and science. But just for that reason, physicians are enjoined to follow the principle of *primum non nocere*: first, do no harm. As McNamara's testimony made clear, "affirming" medicine's preferred framework is: first, give teenagers what they want. "Harm" is conceived as frustrated teenage desire, not the objective modification of the body and the destruction of its natural potentialities. In the "affirmative" worldview, the standard processes by which medical necessity is adduced and implemented exist only as a burden on skeptics to explain why teenagers should not be given what they want. This is deeply perverse. It offends not only medical ethics but also common sense and longstanding social experience.

This deeper disagreement between McNamara and the board members might explain the board's frustrations with her unwillingness to answer simple questions about diagnosis and treatment. The board's physicians seemed to appreciate that in their own work, they are expected to be able to articulate—and defend—objective treatment protocols for scientifically demonstrable conditions. The exchange highlighted the exceptionalism under which "gender-affirming" care operates in medicine. There is no objective criterion for medical necessity of a treatment, which is determined solely by a patient's wish. The stronger the wish, the clearer the necessity.

McNamara was equally evasive when asked why other countries have pulled back significantly on the use of puberty blockers and cross-sex hormones to treat youth gender dysphoria. She seemed to suggest that all these countries have done is require better gathering of data while leaving the affirmative model in place. This is demonstrably false. To give just one example, in her report on the Tavistock clinic prior to the NHS ordering it to close, Hilary Cass, former president of the U.K.'s Royal College of Paediatrics and Child Health, explicitly singled out the "affirmative model" of treatment—which, she said, "originated in the USA"—as a major reason behind the lack of child "safeguarding" and the rushing of minors into medical transition.

Riittakerttu Kaltiala, who leads the largest of Finland's two state-approved pediatric gender clinics and who testified in favor of Florida's proposed rule, has said on a number of occasions that mental-health comorbidities, which are extremely high in female adolescents with adolescent-onset gender dysphoria, should not be assumed to be caused by "unaffirmed" gender self-identification. That co-occurring conditions like anxiety and depression are *due to* lack of acceptance for one's "true gender self," rather than a potential *cause of* gender-related distress, or just symptoms unrelated to any gender issues, is a key assumption behind the affirmative model.

The dramatic climax of McNamara's testimony came near its conclusion, when one of the board members asked whether she has age cutoffs for "top" and "bottom" surgeries: euphemisms for, respectively, double mastectomies and genital surgery. The WPATH recently published its revised standards of care, in which it eliminated age minimums for hormones and surgeries. McNamara, who on occasion cited WPATH as an authority, responded to the surgery question by saying that she has never referred a patient for genital surgery and knows of no such procedure having been done at her university hospital. As for "top surgery" (double mastectomies), McNamara said: "I've never referred a patient for surgery. I've never had a patient express that they desire top surgery. And I've never had to explore that because, again, it's so rare."

Considering McNamara's repeated insinuation—damning to her credibility as a physician, in the view of at least one of the doctors on the Florida board—that her treatment approach is driven by patient wishes, it is worth asking: what are the chances that McNamara in fact hasn't had even a single patient who desired a mastectomy?

One way to assess the credibility of this statement is by examining the statistics on "top surgery." According to data recently compiled by Komodo Health and published by Reuters, in 2019, 3,036 minors were put on cross-sex hormones—typically the "treatment" phase that precedes mastectomies. Because this figure is based on

insurance claims, the actual number is likely quite a bit higher. The Reuters investigation suggests that what has happened in other countries—where data are more systematically and reliably collected—has also happened here: roughly two-thirds of referrals for pediatric gender transition are females. It's reasonable to assume, then, that of the 3,036 put on cross-sex hormones, roughly 2,000 were female. Moreover, according to data published in *JAMA Pediatrics*, roughly 500 minors got double mastectomies for "gender-affirming" purposes during 2019 (there were 100 in 2016). Assuming that these patients had been on cross-sex hormones, that comes out to a hormone-to-surgery conversion rate of 25 percent.

JAMA included only procedures performed in hospitals, not by plastic surgeons in private settings. Because these procedures yield around $10,000 per patient, many mastectomies take place outside of hospitals in surgery centers owned by plastic surgeons themselves. The 25 percent figure is, therefore, very likely an underestimate. Nevertheless, assume it is accurate enough. Assume, also, that the 25 percent hormones-to-surgery conversion rate has remained steady since 2019. If McNamara, who claims to be practicing as a specialist in gender dysphoria, saw even 100 gender-dysphoric females on hormones in her career (a conservative assessment that assumes she sees patients only one day per week and that only a quarter of her patients are gender dysphoric), at least 25 of them should have broached the subject of getting a mastectomy.

What are we to make of her claim that she has never referred a single one even to a consultation with a surgeon? One possibility, though unlikely, is that McNamara lives in an area of the country where teenage girls tend not to want mastectomies. Another possibility is that, apparently unlike other "gender-affirming" doctors, McNamara is remarkably good at helping dissuade her dysphoric patients from surgery. A third is that, her claims to the contrary notwithstanding, McNamara isn't really on board with the "affirmative" model. But the fourth possibility is that McNamara isn't being fully truthful.

The exceptionalism of "gender-affirming" care became evident when Scot Ackerman, an oncologist on the Florida board, pressed McNamara on her gatekeeping role as a physician. "You really are an advocate for gender-affirming care," Ackerman said, "and what I'm hearing from you and other speakers is this is healthy for people, it's healthy for mental health, it's healthy for them in general. So why would you not refer a minor for surgical sex-affirming surgery?" In other words, if this procedure is, as "gender-affirming" advocates like to say, medically necessary and life-saving, and if scientific research supports such claims, then why not declare it proudly? One might paraphrase "affirming" doctors and their activist supporters as follows: surgeries

aren't happening, so stop scaremongering; and surgeries are medically necessary, so it's good that they're happening.

If a gang of amateurs started criticizing oncologists for administering "cruel" chemotherapy, the response from individual oncologists would not be to deny that they ever refer patients for chemo. Rather, the oncologists would say, "Yes, we refer many cancer patients for chemo, and this is how I determine if it is medically necessary." They wouldn't hide behind the mantra that all care is "individualized."

McNamara answered opaquely when asked how doctors at Yale's gender clinic differentiate between gay kids with gender dysphoria and "trans kids," and when asked how they know whether surgery will help or hurt.

But she made one thing crystal clear: teen self-determination drives the choice of medical intervention, including interventions that result in permanent disfigurement and sterility. Is this medicine or corporate customer service?

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Editor's Note: This article has been updated since its initial publication. A reference to a relative of Illinois governor J. B. Pritzker has been corrected.